

1 AN ACT concerning insurance.

2 **Be it enacted by the People of the State of Illinois,**  
3 **represented in the General Assembly:**

4 Section 1. Short title. This Act may be cited as the Health  
5 Carrier External Review Act.

6 Section 5. Purpose and intent. The purpose of this Act is  
7 to provide uniform standards for the establishment and  
8 maintenance of external review procedures to assure that  
9 covered persons have the opportunity for an independent review  
10 of an adverse determination or final adverse determination, as  
11 defined in this Act.

12 Section 10. Definitions. For the purposes of this Act:

13 "Adverse determination" means a determination by a health  
14 carrier or its designee utilization review organization that an  
15 admission, availability of care, continued stay, or other  
16 health care service that is a covered benefit has been reviewed  
17 and, based upon the information provided, does not meet the  
18 health carrier's requirements for medical necessity,  
19 appropriateness, health care setting, level of care, or  
20 effectiveness, and the requested service or payment for the  
21 service is therefore denied, reduced, or terminated.

22 "Authorized representative" means:

1           (1) a person to whom a covered person has given express  
2 written consent to represent the covered person in an  
3 external review;

4           (2) a person authorized by law to provide substituted  
5 consent for a covered person; or

6           (3) a family member of the covered person or the  
7 covered person's health care provider only when the covered  
8 person is unable to provide consent.

9 "Best evidence" means evidence based on:

10           (1) randomized clinical trials;

11           (2) if randomized clinical trials are not available,  
12 then cohort studies or case-control studies;

13           (3) if items (1) and (2) are not available, then  
14 case-series; or

15           (4) if items (1), (2), and (3) are not available, then  
16 expert opinion.

17 "Case-series" means an evaluation of a series of patients  
18 with a particular outcome, without the use of a control group.

19 "Clinical review criteria" means the written screening  
20 procedures, decision abstracts, clinical protocols, and  
21 practice guidelines used by a health carrier to determine the  
22 necessity and appropriateness of health care services.

23 "Cohort study" means a prospective evaluation of 2 groups  
24 of patients with only one group of patients receiving specific  
25 intervention.

26 "Covered benefits" or "benefits" means those health care

1 services to which a covered person is entitled under the terms  
2 of a health benefit plan.

3 "Covered person" means a policyholder, subscriber,  
4 enrollee, or other individual participating in a health benefit  
5 plan.

6 "Director" means the Director of the Division of Insurance  
7 within the Illinois Department of Financial and Professional  
8 Regulation.

9 "Emergency medical condition" means the sudden onset of a  
10 health condition or illness that requires immediate medical  
11 attention, where failure to provide medical attention would  
12 result in a serious impairment to bodily functions, serious  
13 dysfunction of a bodily organ or part, or would place the  
14 person's health in serious jeopardy.

15 "Emergency services" means health care items and services  
16 furnished or required to evaluate and treat an emergency  
17 medical condition.

18 "Evidence-based standard" means the conscientious,  
19 explicit, and judicious use of the current best evidence based  
20 on an overall systematic review of the research in making  
21 decisions about the care of individual patients.

22 "Expert opinion" means a belief or an interpretation by  
23 specialists with experience in a specific area about the  
24 scientific evidence pertaining to a particular service,  
25 intervention, or therapy.

26 "Facility" means an institution providing health care

1 services or a health care setting.

2 "Final adverse determination" means an adverse  
3 determination involving a covered benefit that has been upheld  
4 by a health carrier, or its designee utilization review  
5 organization, at the completion of the health carrier's  
6 internal grievance process procedures as set forth by the  
7 American Accreditation Health Care Commission.

8 "Health benefit plan" means a policy, contract,  
9 certificate, plan, or agreement offered or issued by a health  
10 carrier to provide, deliver, arrange for, pay for, or reimburse  
11 any of the costs of health care services.

12 "Health care provider" or "provider" means a physician or  
13 other health care practitioner licensed, accredited, or  
14 certified to perform specified health care services consistent  
15 with State law, responsible for recommending health care  
16 services on behalf of a covered person.

17 "Health care services" means services for the diagnosis,  
18 prevention, treatment, cure, or relief of a health condition,  
19 illness, injury, or disease.

20 "Health carrier" means an entity subject to the insurance  
21 laws and regulations of this State, or subject to the  
22 jurisdiction of the Director, that contracts or offers to  
23 contract to provide, deliver, arrange for, pay for, or  
24 reimburse any of the costs of health care services, including a  
25 sickness and accident insurance company, a health maintenance  
26 organization, a nonprofit hospital and health service

1 corporation, or any other entity providing a plan of health  
2 insurance, health benefits, or health care services. "Health  
3 carrier" also means Limited Health Service Organizations  
4 (LHSO) and Voluntary Health Service Plans.

5 "Health carrier" does not include a managed care plan as  
6 defined in the Managed Care Reform and Patient Rights Act.

7 "Health information" means information or data, whether  
8 oral or recorded in any form or medium, and personal facts or  
9 information about events or relationships that relate to:

10 (1) the past, present, or future physical, mental, or  
11 behavioral health or condition of an individual or a member  
12 of the individual's family;

13 (2) the provision of health care services to an  
14 individual; or

15 (3) payment for the provision of health care services  
16 to an individual.

17 "Independent review organization" means an entity that  
18 conducts independent external reviews of adverse  
19 determinations and final adverse determinations.

20 "Medical or scientific evidence" means evidence found in  
21 the following sources:

22 (1) peer-reviewed scientific studies published in or  
23 accepted for publication by medical journals that meet  
24 nationally recognized requirements for scientific  
25 manuscripts and that submit most of their published  
26 articles for review by experts who are not part of the

1 editorial staff;

2 (2) peer-reviewed medical literature, including  
3 literature relating to therapies reviewed and approved by a  
4 qualified institutional review board, biomedical  
5 compendia, and other medical literature that meet the  
6 criteria of the National Institutes of Health's Library of  
7 Medicine for indexing in Index Medicus (Medline) and  
8 Elsevier Science Ltd. for indexing in Excerpta Medicus  
9 (EMBASE);

10 (3) medical journals recognized by the Secretary of  
11 Health and Human Services under Section 1861(t)(2) of the  
12 federal Social Security Act;

13 (4) the following standard reference compendia:

14 (a) The American Hospital Formulary Service-Drug  
15 Information;

16 (b) Drug Facts and Comparisons;

17 (c) The American Dental Association Accepted  
18 Dental Therapeutics; and

19 (d) The United States Pharmacopoeia-Drug  
20 Information;

21 (5) findings, studies, or research conducted by or  
22 under the auspices of federal government agencies and  
23 nationally recognized federal research institutes,  
24 including:

25 (a) the federal Agency for Healthcare Research and  
26 Quality;

- 1 (b) the National Institutes of Health;  
2 (c) the National Cancer Institute;  
3 (d) the National Academy of Sciences;  
4 (e) the Centers for Medicare & Medicaid Services;  
5 (f) the federal Food and Drug Administration; and  
6 (g) any national board recognized by the National  
7 Institutes of Health for the purpose of evaluating the  
8 medical value of health care services; or  
9 (6) any other medical or scientific evidence that is  
10 comparable to the sources listed in items (1) through (5).

11 "Protected health information" means health information  
12 (i) that identifies an individual who is the subject of the  
13 information; or (ii) with respect to which there is a  
14 reasonable basis to believe that the information could be used  
15 to identify an individual.

16 "Retrospective review" means a review of medical necessity  
17 conducted after services have been provided to a patient, but  
18 does not include the review of a claim that is limited to an  
19 evaluation of reimbursement levels, veracity of documentation,  
20 accuracy of coding, or adjudication for payment.

21 "Utilization review" has the meaning provided by the  
22 American Accreditation Health Care Commission.

23 "Utilization review organization" means a utilization  
24 review program as defined by the American Accreditation Health  
25 Care Commission.

1 Section 15. Applicability and scope.

2 (a) Except as provided in subsection (b) of this Section,  
3 this Act shall apply to all health carriers.

4 (b) The provisions of this Act shall not apply to a policy  
5 or certificate that provides coverage only for a specified  
6 disease, specified accident or accident-only coverage, credit,  
7 dental, disability income, hospital indemnity, long-term care  
8 insurance as defined by Article XIXA of the Illinois Insurance  
9 Code, vision care, or any other limited supplemental benefit; a  
10 Medicare supplement policy of insurance as defined by the  
11 Director by regulation; coverage under a plan through Medicare,  
12 Medicaid, or the federal employees health benefits program; any  
13 coverage issued under Chapter 55 of Title 10, U.S. Code and any  
14 coverage issued as supplement to that coverage; any coverage  
15 issued as supplemental to liability insurance, workers'  
16 compensation, or similar insurance; automobile medical-payment  
17 insurance or any insurance under which benefits are payable  
18 with or without regard to fault, whether written on a group  
19 blanket or individual basis; or any managed care plan as  
20 defined in the Managed Care Reform and Patient Rights Act.

21 Section 20. Notice of right to external review.

22 (a) At the same time the health carrier sends written  
23 notice of an adverse determination upon completion of the  
24 health carrier's utilization review process as provided by the  
25 American Accreditation Health Care Commission and a final

1 adverse determination, a health carrier shall notify a covered  
2 person and a covered person's health care provider in writing  
3 of the covered person's right to request an external review as  
4 provided by this Act.

5 (1) The written notice required shall include the  
6 following, or substantially equivalent, language: "We have  
7 denied your request for the provision of or payment for a  
8 health care service or course of treatment. You have the  
9 right to have our decision reviewed by an independent  
10 review organization not associated with us if our decision  
11 involved making a judgment as to the medical necessity,  
12 appropriateness, health care setting, level of care, or  
13 effectiveness of the health care service or treatment you  
14 requested by submitting a written request for an external  
15 review to us. Upon receipt of your request an independent  
16 review organization registered with the Department of  
17 Financial and Professional Regulation, Division of  
18 Insurance will be assigned to review our decision."

19 (2) The notice shall also include the appropriate  
20 statements and information set forth in subsections (b) and  
21 (c) of this Section.

22 (b) The health carrier shall include in the notice required  
23 under subsection (a) of this Section for a notice related to an  
24 adverse determination, a statement informing the covered  
25 person that:

26 (1) if the covered person has a medical condition where

1 the timeframe for completion of an expedited internal  
2 review of a grievance involving an adverse determination  
3 would seriously jeopardize the life or health of the  
4 covered person or would jeopardize the covered person's  
5 ability to regain maximum function or if the adverse  
6 determination involves a denial of coverage based on a  
7 determination that the recommended or requested health  
8 care service or treatment is experimental or  
9 investigational and the covered person's treating  
10 physician certifies in writing that the recommended or  
11 requested health care service or treatment that is the  
12 subject of the adverse determination would be  
13 significantly less effective if not promptly initiated,  
14 then the covered person or the covered person's authorized  
15 representative may file a request for an expedited external  
16 review at the same time the covered person or the covered  
17 person's authorized representative files a request for an  
18 expedited internal appeal involving an adverse  
19 determination as set forth by the American Accreditation  
20 Health Care Commission. The independent review  
21 organization assigned to conduct the expedited external  
22 review will determine whether the covered person shall be  
23 required to complete the expedited review of the grievance  
24 prior to conducting the expedited external review; and

25 (2) the covered person or the covered person's  
26 authorized representative may file a grievance under the

1 health carrier's internal grievance process as set forth by  
2 the American Accreditation Health Care Commission, but if  
3 the health carrier has not issued a written decision to the  
4 covered person or the covered person's authorized  
5 representative within 30 days following the date the  
6 covered person or the covered person's authorized  
7 representative files the grievance with the health carrier  
8 and the covered person or the covered person's authorized  
9 representative has not requested or agreed to a delay, then  
10 the covered person or the covered person's authorized  
11 representative may file a request for external review and  
12 shall be considered to have exhausted the health carrier's  
13 internal grievance process.

14 (c) The health carrier shall include in the notice required  
15 under subsection (a) of this Section for a notice related to a  
16 final adverse determination, a statement informing the covered  
17 person that:

18 (1) if the covered person has a medical condition where  
19 the timeframe for completion of a standard external review  
20 would seriously jeopardize the life or health of the  
21 covered person or would jeopardize the covered person's  
22 ability to regain maximum function, then the covered person  
23 or the covered person's authorized representative may file  
24 a request for an expedited external review; or

25 (2) if a final adverse determination concerns:

26 (i) an admission, availability of care, continued

1 stay, or health care service for which the covered  
2 person received emergency services, but has not been  
3 discharged from a facility, then the covered person, or  
4 the covered person's authorized representative, may  
5 request an expedited external review; or

6 (ii) a denial of coverage based on a determination  
7 that the recommended or requested health care service  
8 or treatment is experimental or investigational, and  
9 the covered person's health care provider certifies in  
10 writing that the recommended or requested health care  
11 service or treatment that is the subject of the request  
12 would be significantly less effective if not promptly  
13 initiated, then the covered person or the covered  
14 person's authorized representative may request an  
15 expedited external review.

16 (d) In addition to the information to be provided pursuant  
17 to subsections (a), (b), and (c) of this Section, the health  
18 carrier shall include a copy of the description of both the  
19 required standard and expedited external review procedures.  
20 The description shall highlight the external review procedures  
21 that give the covered person or the covered person's authorized  
22 representative the opportunity to submit additional  
23 information, including any forms used to process an external  
24 review.

25 Section 25. Request for external review. A covered person

1 or the covered person's authorized representative may make a  
2 request for a standard external or expedited external review of  
3 an adverse determination or final adverse determination.  
4 Requests under this Section shall be made directly to the  
5 health carrier that made the adverse or final adverse  
6 determination. All requests for external review shall be in  
7 writing except for requests for expedited external reviews  
8 which may be made orally. Health carriers must provide covered  
9 persons with forms to request external reviews.

10 Section 30. Exhaustion of internal grievance process.

11 (a) Except as provided in item (1) of subsection (b) of  
12 Section 20 of this Act, a request for an external review shall  
13 not be made until the covered person has exhausted the health  
14 carrier's internal grievance process as set forth by the  
15 American Accreditation Health Care Commission.

16 (b) A covered person shall be considered to have exhausted  
17 the health carrier's internal grievance process for purposes of  
18 this Section if the covered person or the covered person's  
19 authorized representative filed a request for an internal  
20 review of an adverse determination pursuant to the American  
21 Accreditation Health Care Commission and has not received a  
22 written decision on the request from the health carrier within  
23 30 days after the request is filed, except to the extent the  
24 covered person or the covered person's authorized  
25 representative requested or agreed to a delay.

1           (c) Notwithstanding subsection (b) of this Section, a  
2 covered person or the covered person's authorized  
3 representative may not make a request for an external review of  
4 an adverse determination involving a retrospective review  
5 determination until the covered person has exhausted the health  
6 carrier's internal grievance process.

7           (d) Upon request for an expedited external review pursuant  
8 to item (1) of subsection (b) of Section 20 of this Act, the  
9 independent review organization conducting the external review  
10 shall determine whether the covered person shall be required to  
11 complete the expedited review process set forth by the American  
12 Accreditation Health Care Commission before it conducts the  
13 expedited external review. Upon determination that the covered  
14 person must first complete the expedited grievance review  
15 process, the independent review organization immediately shall  
16 notify the covered person and, if applicable, the covered  
17 person's authorized representative of this determination and  
18 that it will not proceed with the expedited external review  
19 until completion of the expedited grievance review process and  
20 that covered person's grievance at the completion of the  
21 expedited grievance review process remains unresolved.

22           (e) A covered person need not exhaust a health carrier's  
23 internal grievance procedures as set forth by the American  
24 Accreditation Health Care Commission, if the health carrier  
25 agrees to waive the exhaustion requirement.

1 Section 35. Standard external review.

2 (a) Within 4 months after the date of receipt of a notice  
3 of an adverse determination or final adverse determination, a  
4 covered person or the covered person's authorized  
5 representative may file a request for an external review with  
6 the health carrier.

7 (b) Within 5 business days following the date of receipt of  
8 the external review request, the health carrier shall complete  
9 a preliminary review of the request to determine whether:

10 (1) the individual is or was a covered person in the  
11 health benefit plan at the time the health care service was  
12 requested or at the time the health care service was  
13 provided;

14 (2) either of the following situations is applicable:

15 (A) the health care service that is the subject of  
16 the adverse determination or the final adverse  
17 determination is a covered service under the covered  
18 person's health benefit plan, but the health carrier  
19 has determined that the health care service is not  
20 covered because it does not meet the health carrier's  
21 requirements for medical necessity, appropriateness,  
22 health care setting, level of care, or effectiveness;  
23 or

24 (B) the recommended or requested health care  
25 service or treatment that is the subject of the adverse  
26 determination or final adverse determination is a

1 covered benefit under the covered person's health  
2 benefit plan except for the health carrier's  
3 determination that the service or treatment is  
4 experimental or investigational for a particular  
5 medical condition and is not explicitly listed as an  
6 excluded benefit under the covered person's health  
7 benefit plan with the health carrier;

8 (3) the covered person's treating physician has  
9 certified that one of the following situations is  
10 applicable:

11 (A) standard health care services or treatments  
12 have not been effective in improving the condition of  
13 the covered person;

14 (B) standard health care services or treatments  
15 are not medically appropriate for the covered person;  
16 or

17 (C) there is no available standard health care  
18 service or treatment covered by the health carrier that  
19 is more beneficial than the recommended or requested  
20 health care service or treatment described in item (4)  
21 of this subsection (b);

22 (4) the covered person's treating physician:

23 (A) has recommended a health care service or  
24 treatment that the physician certifies, in writing, is  
25 likely to be more beneficial to the covered person, in  
26 the physician's opinion, than any available standard

1 health care service or treatment; or

2 (B) who is a licensed, board certified, or board  
3 eligible physician qualified to practice in the area of  
4 medicine appropriate to treat the covered person's  
5 condition, has certified in writing that  
6 scientifically valid studies using accepted protocols  
7 demonstrate that the health care service or treatment  
8 requested by the covered person that is the subject of  
9 the adverse determination or final adverse  
10 determination is likely to be more beneficial to the  
11 covered person than any available standard health care  
12 services or treatments;

13 (5) the covered person has exhausted the health  
14 carrier's internal grievance process as set forth in  
15 Section 30 of this Act; and

16 (6) the covered person has provided all the information  
17 and forms required to process an external review as  
18 specified in this Act.

19 (c) Within one business day after completion of the  
20 preliminary review, the health carrier shall notify the covered  
21 person and, if applicable, the covered person's authorized  
22 representative in writing whether the request is complete and  
23 eligible for external review. If the request:

24 (1) is not complete, the health carrier shall inform  
25 the covered person and, if applicable, the covered person's  
26 authorized representative in writing and include in the

1 notice what information or materials are required by this  
2 Act to make the request complete; or

3 (2) is not eligible for external review, the health  
4 carrier shall inform the covered person and, if applicable,  
5 the covered person's authorized representative in writing  
6 and include in the notice the reasons for its  
7 ineligibility.

8 The notice of initial determination of ineligibility shall  
9 include a statement informing the covered person and, if  
10 applicable, the covered person's authorized representative  
11 that a health carrier's initial determination that the external  
12 review request is ineligible for review may be appealed to the  
13 Director by filing a complaint with the Director.

14 Notwithstanding a health carrier's initial determination  
15 that the request is ineligible for external review, the  
16 Director may determine that a request is eligible for external  
17 review and require that it be referred for external review. In  
18 making such determination, the Director's decision shall be in  
19 accordance with the terms of the covered person's health  
20 benefit plan and shall be subject to all applicable provisions  
21 of this Act.

22 (d) Whenever a request is eligible for external review the  
23 health carrier shall, within 5 business days:

24 (1) assign an independent review organization from the  
25 list of approved independent review organizations compiled  
26 and maintained by the Director; and

1           (2) notify in writing the covered person and, if  
2           applicable, the covered person's authorized representative  
3           of the request's eligibility and acceptance for external  
4           review and the name of the independent review organization.

5           The health carrier shall include in the notice provided to  
6           the covered person and, if applicable, the covered person's  
7           authorized representative a statement that the covered person  
8           or the covered person's authorized representative may, within 5  
9           business days following the date of receipt of the notice  
10          provided pursuant to item (2) of this subsection (d), submit in  
11          writing to the assigned independent review organization  
12          additional information that the independent review  
13          organization shall consider when conducting the external  
14          review. The independent review organization is not required to,  
15          but may, accept and consider additional information submitted  
16          after 5 business days.

17          (e) The assignment of an approved independent review  
18          organization to conduct an external review in accordance with  
19          this Section shall be done on a random basis among those  
20          approved independent review organizations qualified to conduct  
21          external review except for instances of conflict of interest  
22          concerns pursuant to this Act.

23          (f) Upon assignment of an independent review organization,  
24          the health carrier or its designee utilization review  
25          organization shall, within 5 business days, provide to the  
26          assigned independent review organization the documents and any

1 information considered in making the adverse determination or  
2 final adverse determination; in such cases, the following  
3 provisions shall apply:

4 (1) Except as provided in item (2) of this subsection  
5 (f), failure by the health carrier or its utilization  
6 review organization to provide the documents and  
7 information within the specified time frame shall not delay  
8 the conduct of the external review.

9 (2) If the health carrier or its utilization review  
10 organization fails to provide the documents and  
11 information within the specified time frame, the assigned  
12 independent review organization may terminate the external  
13 review and make a decision to reverse the adverse  
14 determination or final adverse determination.

15 (3) Within one business day after making the decision  
16 to terminate the external review and make a decision to  
17 reverse the adverse determination or final adverse  
18 determination under item (2) of this subsection (f), the  
19 independent review organization shall notify the health  
20 carrier, the covered person and, if applicable, the covered  
21 person's authorized representative, of its decision to  
22 reverse the adverse determination.

23 (g) Upon receipt of the information from the health carrier  
24 or its utilization review organization, the assigned  
25 independent review organization shall review all of the  
26 information and documents and any other information submitted

1 in writing to the independent review organization by the  
2 covered person and the covered person's authorized  
3 representative.

4 (h) Upon receipt of any information submitted by the  
5 covered person or the covered person's authorized  
6 representative, the independent review organization shall  
7 forward the information to the health carrier within 1 business  
8 day.

9 (1) Upon receipt of the information, if any, the health  
10 carrier may reconsider its adverse determination or final  
11 adverse determination that is the subject of the external  
12 review.

13 (2) Reconsideration by the health carrier of its  
14 adverse determination or final adverse determination shall  
15 not delay or terminate the external review.

16 (3) The external review may only be terminated if the  
17 health carrier decides, upon completion of its  
18 reconsideration, to reverse its adverse determination or  
19 final adverse determination and provide coverage or  
20 payment for the health care service that is the subject of  
21 the adverse determination or final adverse determination.  
22 In such cases, the following provisions shall apply:

23 (A) Within one business day after making the  
24 decision to reverse its adverse determination or final  
25 adverse determination, the health carrier shall notify  
26 the covered person, if applicable, the covered

1 person's authorized representative, and the assigned  
2 independent review organization in writing of its  
3 decision.

4 (B) Upon notice from the health carrier that the  
5 health carrier has made a decision to reverse its  
6 adverse determination or final adverse determination,  
7 the assigned independent review organization shall  
8 terminate the external review.

9 (i) In addition to the documents and information provided  
10 by the health carrier or its utilization review organization  
11 and the covered person and the covered person's authorized  
12 representative, if any, the independent review organization,  
13 to the extent the information or documents are available and  
14 the independent review organization considers them  
15 appropriate, shall consider the following in reaching a  
16 decision:

17 (1) for an adverse determination or final adverse  
18 determination:

19 (A) the covered person's pertinent medical  
20 records;

21 (B) the covered person's health care provider's  
22 recommendation;

23 (C) consulting reports from appropriate health  
24 care providers and other documents submitted by the  
25 health carrier, the covered person, the covered  
26 person's authorized representative, or the covered

1 person's treating provider;

2 (D) the terms of coverage under the covered  
3 person's health benefit plan with the health carrier to  
4 ensure that the independent review organization's  
5 decision is not contrary to the terms of coverage under  
6 the covered person's health benefit plan with the  
7 health carrier;

8 (E) the most appropriate practice guidelines,  
9 which shall include applicable evidence-based  
10 standards and may include any other practice  
11 guidelines developed by the federal government,  
12 national or professional medical societies, boards,  
13 and associations;

14 (F) any applicable clinical review criteria  
15 developed and used by the health carrier or its  
16 designee utilization review organization; and

17 (G) the opinion of the independent review  
18 organization's clinical reviewer or reviewers after  
19 considering paragraphs (A) through (G) of this item (1)  
20 of this subsection (i) to the extent the information or  
21 documents are available and the clinical reviewer or  
22 reviewers considers the information or documents  
23 appropriate;

24 (2) for an adverse determination or final adverse  
25 determination that involves a denial of coverage based on a  
26 determination that the health care service or treatment

1 recommended or requested is experimental or  
2 investigational:

3 (A) the covered person's pertinent medical  
4 records;

5 (B) the covered person's health care provider's  
6 recommendation;

7 (C) consulting reports from appropriate health  
8 care providers and other documents submitted by the  
9 health carrier, the covered person, the covered  
10 person's authorized representative, or the covered  
11 person's treating physician or health care  
12 professional;

13 (D) the terms of coverage under the covered  
14 person's health benefit plan with the health carrier to  
15 ensure that, but for the health carrier's  
16 determination that the recommended or requested health  
17 care service or treatment that is the subject of the  
18 opinion is experimental or investigational, the  
19 independent review organization's opinion is not  
20 contrary to the terms of coverage under the covered  
21 person's health benefit plan with the health carrier;  
22 and

23 (E) whether and to what extent:

24 (i) the recommended or requested health care  
25 service or treatment has been approved by the  
26 federal Food and Drug Administration, if

1 applicable, for the condition; or  
2 (ii) medical or scientific evidence or  
3 evidence-based standards demonstrate that the  
4 expected benefits of the recommended or requested  
5 health care service or treatment is more likely  
6 than not to be beneficial to the covered person  
7 than any available standard health care service or  
8 treatment and the adverse risks of the recommended  
9 or requested health care service or treatment  
10 would not be substantially increased over those of  
11 available standard health care services or  
12 treatments; or

13 (3) except for an expedited external review, for an  
14 adverse determination or final adverse determination that  
15 involves a denial of coverage based on a determination that  
16 the health care service or treatment recommended or  
17 requested is experimental or investigational, each  
18 clinical reviewer selected by the independent review  
19 organization shall provide its opinion to the independent  
20 review organization in writing and include the following  
21 information:

22 (A) a description of the covered person's medical  
23 condition;

24 (B) a description of the indicators relevant to  
25 determining whether there is sufficient evidence to  
26 demonstrate that the recommended or requested health

1 care service or treatment is more likely than not to be  
2 beneficial to the covered person than any available  
3 standard health care services or treatments and the  
4 adverse risks of the recommended or requested health  
5 care service or treatment would not be substantially  
6 increased over those of available standard health care  
7 services or treatments;

8 (C) a description and analysis of any medical or  
9 scientific evidence considered in reaching the  
10 opinion;

11 (D) a description and analysis of any  
12 evidence-based standard; and

13 (E) information on whether the reviewer's  
14 rationale for the opinion is based on paragraphs (i) or  
15 (ii) of subitem (E) of item (2) of this subsection (i).

16 (j) Within 5 days after the date of receipt of all  
17 necessary information, the assigned independent review  
18 organization shall provide written notice of its decision to  
19 uphold or reverse the adverse determination or the final  
20 adverse determination to the health carrier, the covered person  
21 and, if applicable, the covered person's authorized  
22 representative. In reaching a decision, the assigned  
23 independent review organization is not bound by any decisions  
24 or conclusions reached during the health carrier's utilization  
25 review process as set forth by the American Accreditation  
26 Health Care Commission. In such cases, the following provisions

1 shall apply:

2 (1) The independent review organization shall include  
3 in the notice:

4 (A) a general description of the reason for the  
5 request for external review;

6 (B) the date the independent review organization  
7 received the assignment from the health carrier to  
8 conduct the external review;

9 (C) the time period during which the external  
10 review was conducted;

11 (D) references to the evidence or documentation,  
12 including the evidence-based standards, considered in  
13 reaching its decision.

14 (E) the date of its decision; and

15 (F) the principal reason or reasons for its  
16 decision, including what applicable, if any,  
17 evidence-based standards that were a basis for its  
18 decision.

19 (2) For reviews of experimental or investigational  
20 treatments, the notice shall include the following  
21 information:

22 (A) a general description of the reason for the  
23 request for external review;

24 (B) the written opinion of each clinical reviewer,  
25 including the recommendation of each clinical reviewer  
26 as to whether the recommended or requested health care

1 service or treatment should be covered and the  
2 rationale for the reviewer's recommendation;

3 (C) the date that the independent review  
4 organization received assignment from the health  
5 carrier to conduct the external review;

6 (D) the time period during which the external  
7 review was conducted; and

8 (E) the principal reason or reasons for its  
9 decision.

10 (3) Upon receipt of a notice of a decision reversing  
11 the adverse determination or final adverse determination,  
12 the health carrier immediately shall approve the coverage  
13 that was the subject of the adverse determination or final  
14 adverse determination.

15 Section 40. Expedited external review.

16 (a) A covered person or a covered person's authorized  
17 representative may file a request for an expedited external  
18 review with the health carrier either orally or in writing at  
19 the time the covered person receives:

20 (1) an adverse determination, if:

21 (A) the adverse determination involves a medical  
22 condition of the covered person for which the timeframe  
23 for completion of an expedited internal review of a  
24 grievance involving an adverse determination as set  
25 forth by the American Accreditation Health Care

1 Commission would seriously jeopardize the life or  
2 health of the covered person or would jeopardize the  
3 covered person's ability to regain maximum function;  
4 and

5 (B) the covered person or the covered person's  
6 authorized representative has filed a request for an  
7 expedited review of a grievance involving an adverse  
8 determination as set forth by the American  
9 Accreditation Health Care Commission; or

10 (2) a final adverse determination, if:

11 (A) the covered person has a medical condition  
12 where the timeframe for completion of a standard  
13 external review would seriously jeopardize the life or  
14 health of the covered person or would jeopardize the  
15 covered person's ability to regain maximum function;  
16 or

17 (B) the final adverse determination concerns an  
18 admission, availability of care, continued stay, or  
19 health care service for which the covered person  
20 received emergency services but has not been  
21 discharged from a facility.

22 (b) Upon receipt of a request for an expedited external  
23 review as provided in Section 20 of this Act, the health  
24 carrier shall determine whether the request meets the  
25 reviewability requirements set forth in subsection (b) of  
26 Section 35 of this Act. The health carrier shall immediately

1 notify the covered person and, if applicable, the covered  
2 person's authorized representative of its eligibility  
3 determination. The notice of initial determination shall  
4 include a statement informing the covered person and, if  
5 applicable, the covered person's authorized representative  
6 that a health carrier's initial determination that an external  
7 review request is ineligible for review may be appealed to the  
8 Director.

9 (c) The Director may determine that a request is eligible  
10 for external review under subsection (b) of Section 35 of this  
11 Act, notwithstanding a health carrier's initial determination  
12 that the request is ineligible and require that it be referred  
13 for external review. In making a determination, the Director's  
14 decision shall be made in accordance with the terms of the  
15 covered person's health benefit plan and shall be subject to  
16 all applicable provisions of this Act.

17 (d) Whenever a request is eligible for external review, the  
18 health carrier shall immediately assign an independent review  
19 organization from the list of approved independent review  
20 organizations compiled and maintained by the Director to  
21 conduct the expedited review. In such cases, the following  
22 provisions shall apply:

23 (1) The assignment by the health carrier of an approved  
24 independent review organization to conduct an external  
25 review in accordance with this Section shall be done on a  
26 random basis among those approved independent review

1 organizations except as may be prohibited by conflict of  
2 interest concerns pursuant to Section 60 of this Act.

3 (2) Immediately upon assigning an independent review  
4 organization to perform an expedited external review, but  
5 in no case less than 24 hours after assigning the  
6 independent review organization, the health carrier or its  
7 designee utilization review organization shall provide or  
8 transmit all necessary documents and information  
9 considered in making the final adverse determination to the  
10 assigned independent review organization electronically or  
11 by telephone or facsimile or any other available  
12 expeditious method.

13 (3) If the health carrier or its utilization review  
14 organization fails to provide the documents and  
15 information within the specified timeframe, the assigned  
16 independent review organization may terminate the external  
17 review and make a decision to reverse the adverse  
18 determination or final adverse determination.

19 (4) Within one business day after making the decision  
20 to terminate the external review and make a decision to  
21 reverse the adverse determination or final adverse  
22 determination under item (2) of this subsection (d), the  
23 independent review organization shall notify the health  
24 carrier, the covered person and, if applicable, the covered  
25 person's authorized representative of its decision to  
26 reverse the adverse determination.

1           (e) In addition to the documents and information provided  
2 by the health carrier or its utilization review organization  
3 and any documents and information provided by the covered  
4 person and the covered person's authorized representative, the  
5 independent review organization shall consider the following  
6 in reaching a decision:

7           (1) for an adverse determination or final adverse  
8 determination, the provisions included in subitems (A)  
9 through (G) of item (1) of subsection (i) of Section 35 of  
10 this Act; or

11           (2) for an adverse determination or final adverse  
12 determination that involves a denial of coverage based on a  
13 determination that the health care service or treatment  
14 recommended or requested is experimental or  
15 investigational, the provisions included in subitems (A)  
16 through (E) of item (2) of subsection (i) of Section 35 of  
17 this Act.

18           (f) As expeditiously as the covered person's medical  
19 condition or circumstances requires, but in no event more than  
20 72 hours after the receipt of all pertinent information, the  
21 assigned independent review organization shall:

22           (1) make a decision to uphold or reverse the final  
23 adverse determination; and

24           (2) notify the health carrier, the covered person, the  
25 covered person's health care provider, and if applicable,  
26 the covered person's authorized representative, of the

1 decision.

2 (g) In reaching a decision, the assigned independent review  
3 organization is not bound by any decisions or conclusions  
4 reached during the health carrier's utilization review process  
5 or the health carrier's internal grievance process as set forth  
6 by the American Accreditation Health Care Commission.

7 (h) Upon receipt of notice of a decision reversing the  
8 final adverse determination, the health carrier shall  
9 immediately approve the coverage that was the subject of the  
10 final adverse determination. Within 48 hours after the date of  
11 providing the notice required in this subsection (h), the  
12 assigned independent review organization shall provide written  
13 confirmation of the decision to the health carrier, the covered  
14 person, and if applicable, the covered person's authorized  
15 representative including the information set forth in  
16 subsection (j) of Section 35 of this Act as applicable.

17 (i) An expedited external review may not be provided for  
18 retrospective adverse or final adverse determinations.

19 Section 45. Binding nature of external review decision. An  
20 external review decision is binding on the health carrier. An  
21 external review decision is binding on the covered person  
22 except to the extent the covered person has other remedies  
23 available under applicable federal or State law. A covered  
24 person or the covered person's authorized representative may  
25 not file a subsequent request for external review involving the

1 same adverse determination or final adverse determination for  
2 which the covered person has already received an external  
3 review decision pursuant to this Act.

4 Section 50. Approval of independent review organizations.

5 (a) The Director shall approve independent review  
6 organizations eligible to be assigned to conduct external  
7 reviews under this Act.

8 (b) In order to be eligible for approval by the Director  
9 under this Section to conduct external reviews under this Act  
10 an independent review organization:

11 (1) except as otherwise provided in this Section, shall  
12 be accredited by a nationally recognized private  
13 accrediting entity that the Director has determined has  
14 independent review organization accreditation standards  
15 that are equivalent to or exceed the minimum qualifications  
16 for independent review; and

17 (2) shall submit an application for approval in  
18 accordance with subsection (d) of this Section.

19 (c) The Director shall develop an application form for  
20 initially approving and for reapproving independent review  
21 organizations to conduct external reviews.

22 (d) Any independent review organization wishing to be  
23 approved to conduct external reviews under this Act shall  
24 submit the application form and include with the form all  
25 documentation and information necessary for the Director to

1 determine if the independent review organization satisfies the  
2 minimum qualifications established under this Act. The  
3 Director may:

4 (1) approve independent review organizations that are  
5 not accredited by a nationally recognized private  
6 accrediting entity if there are no acceptable nationally  
7 recognized private accrediting entities providing  
8 independent review organization accreditation; and

9 (2) by rule establish an application fee that  
10 independent review organizations shall submit to the  
11 Director with an application for approval and renewing.

12 (e) An approval is effective for 2 years, unless the  
13 Director determines before its expiration that the independent  
14 review organization is not satisfying the minimum  
15 qualifications established under this Act.

16 (f) Whenever the Director determines that an independent  
17 review organization has lost its accreditation or no longer  
18 satisfies the minimum requirements established under this Act,  
19 the Director shall terminate the approval of the independent  
20 review organization and remove the independent review  
21 organization from the list of independent review organizations  
22 approved to conduct external reviews under this Act that is  
23 maintained by the Director.

24 (g) The Director shall maintain and periodically update a  
25 list of approved independent review organizations.

26 (h) The Director may promulgate regulations to carry out

1 the provisions of this Section.

2 Section 55. Minimum qualifications for independent review  
3 organizations.

4 (a) To be approved to conduct external reviews, an  
5 independent review organization shall have and maintain  
6 written policies and procedures that govern all aspects of both  
7 the standard external review process and the expedited external  
8 review process set forth in this Act that include, at a  
9 minimum:

10 (1) a quality assurance mechanism that ensures that:

11 (A) external reviews are conducted within the  
12 specified timeframes and required notices are provided  
13 in a timely manner;

14 (B) selection of qualified and impartial clinical  
15 reviewers to conduct external reviews on behalf of the  
16 independent review organization and suitable matching  
17 of reviewers to specific cases and that the independent  
18 review organization employs or contracts with an  
19 adequate number of clinical reviewers to meet this  
20 objective;

21 (C) the health carrier, the covered person, and the  
22 covered person's authorized representative shall not  
23 choose or control the choice of the physicians or other  
24 health care professionals to be selected to conduct the  
25 external review;

1 (D) confidentiality of medical and treatment  
2 records and clinical review criteria; and

3 (E) any person employed by or under contract with  
4 the independent review organization adheres to the  
5 requirements of this Act;

6 (2) a toll-free telephone service operating on a  
7 24-hour-day, 7-day-a-week basis that accepts, receives,  
8 and records information related to external reviews and  
9 provides appropriate instructions; and

10 (3) an agreement to maintain and provide to the  
11 Director the information set out in Section 70 of this Act.

12 (b) All clinical reviewers assigned by an independent  
13 review organization to conduct external reviews shall be  
14 physicians or other appropriate health care providers who meet  
15 the following minimum qualifications:

16 (1) be an expert in the treatment of the covered  
17 person's medical condition that is the subject of the  
18 external review;

19 (2) be knowledgeable about the recommended health care  
20 service or treatment through recent or current actual  
21 clinical experience treating patients with the same or  
22 similar medical condition of the covered person;

23 (3) hold a non-restricted license in a state of the  
24 United States and, for physicians, a current certification  
25 by a recognized American medical specialty board in the  
26 area or areas appropriate to the subject of the external

1 review;

2 (4) have no history of disciplinary actions or  
3 sanctions, including loss of staff privileges or  
4 participation restrictions, that have been taken or are  
5 pending by any hospital, governmental agency or unit, or  
6 regulatory body that raise a substantial question as to the  
7 clinical reviewer's physical, mental, or professional  
8 competence or moral character; and

9 (5) for purposes of conducting an external review of  
10 experimental or investigational treatment adverse  
11 determinations, through clinical experience in the past 3  
12 years, be an expert in the treatment of the covered  
13 person's condition and knowledgeable about the recommended  
14 or requested health care service or treatment; neither the  
15 covered person, the covered person's authorized  
16 representative, if applicable, nor the health carrier  
17 shall choose or control the choice of the physicians or  
18 other health care professionals selected to conduct the  
19 external review.

20 (c) In addition to the requirements set forth in subsection  
21 (a), an independent review organization may not own or control,  
22 be a subsidiary of, or in any way be owned, or controlled by,  
23 or exercise control with a health benefit plan, a national,  
24 State, or local trade association of health benefit plans, or a  
25 national, State, or local trade association of health care  
26 providers.

1 (d) Conflicts of interest prohibited. In addition to the  
2 requirements set forth in subsections (a), (b), and (c) of this  
3 Section, to be approved pursuant to this Act to conduct an  
4 external review of a specified case, neither the independent  
5 review organization selected to conduct the external review nor  
6 any clinical reviewer assigned by the independent organization  
7 to conduct the external review may have a material  
8 professional, familial or financial conflict of interest with  
9 any of the following:

10 (1) the health carrier that is the subject of the  
11 external review;

12 (2) the covered person whose treatment is the subject  
13 of the external review or the covered person's authorized  
14 representative;

15 (3) any officer, director or management employee of the  
16 health carrier that is the subject of the external review;

17 (4) the health care provider, the health care  
18 provider's medical group or independent practice  
19 association recommending the health care service or  
20 treatment that is the subject of the external review;

21 (5) the facility at which the recommended health care  
22 service or treatment would be provided; or

23 (6) the developer or manufacturer of the principal  
24 drug, device, procedure, or other therapy being  
25 recommended for the covered person whose treatment is the  
26 subject of the external review.

1 (e) An independent review organization that is accredited  
2 by a nationally recognized private accrediting entity that has  
3 independent review accreditation standards that the Director  
4 has determined are equivalent to or exceed the minimum  
5 qualifications of this Section shall be presumed to be in  
6 compliance with this Section and shall be eligible for approval  
7 under this Section.

8 (f) An independent review organization shall be unbiased.  
9 An independent review organization shall establish and  
10 maintain written procedures to ensure that it is unbiased in  
11 addition to any other procedures required under this Section.

12 Section 60. Hold harmless for independent review  
13 organizations. No independent review organization or clinical  
14 reviewer working on behalf of an independent review  
15 organization or an employee, agent or contractor of an  
16 independent review organization shall be liable for damages to  
17 any person for any opinions rendered or acts or omissions  
18 performed within the scope of the organization's or person's  
19 duties under the law during or upon completion of an external  
20 review conducted pursuant to this Act, unless the opinion was  
21 rendered or act or omission performed in bad faith or involved  
22 gross negligence.

23 Section 65. External review reporting requirements.

24 (a) Each health carrier shall maintain written records in

1 the aggregate on all requests for external review for each  
2 calendar year and submit a report to the Director in the format  
3 specified by the Director by March 1 of each year.

4 (b) The report shall include in the aggregate:

5 (1) the total number of requests for external review;

6 (2) the total number of requests for expedited external  
7 review;

8 (3) the total number of requests for external review  
9 denied;

10 (4) the number of requests for external review  
11 resolved, including:

12 (A) the number of requests for external review  
13 resolved upholding the adverse determination or final  
14 adverse determination;

15 (B) the number of requests for external review  
16 resolved reversing the adverse determination or final  
17 adverse determination;

18 (C) the number of requests for expedited external  
19 review resolved upholding the adverse determination or  
20 final adverse determination; and

21 (D) the number of requests for expedited external  
22 review resolved reversing the adverse determination or  
23 final adverse determination;

24 (5) the average length of time for resolution for an  
25 external review;

26 (6) the average length of time for resolution for an

1 expedited external review;

2 (7) a summary of the types of coverages or cases for  
3 which an external review was sought, as specified below:

4 (A) denial of care or treatment (dissatisfaction  
5 regarding prospective non-authorization of a request  
6 for care or treatment recommended by a provider  
7 excluding diagnostic procedures and referral requests;  
8 partial approvals and care terminations are also  
9 considered to be denials);

10 (B) denial of diagnostic procedure  
11 (dissatisfaction regarding prospective  
12 non-authorization of a request for a diagnostic  
13 procedure recommended by a provider; partial approvals  
14 are also considered to be denials);

15 (C) denial of referral request (dissatisfaction  
16 regarding non-authorization of a request for a  
17 referral to another provider recommended by a PCP);

18 (D) claims and utilization review (dissatisfaction  
19 regarding the concurrent or retrospective evaluation  
20 of the coverage, medical necessity, efficiency or  
21 appropriateness of health care services or treatment  
22 plans; prospective "Denials of care or treatment",  
23 "Denials of diagnostic procedures" and "Denials of  
24 referral requests" should not be classified in this  
25 category, but the appropriate one above);

26 (8) the number of external reviews that were terminated

1 as the result of a reconsideration by the health carrier of  
2 its adverse determination or final adverse determination  
3 after the receipt of additional information from the  
4 covered person or the covered person's authorized  
5 representative; and

6 (9) any other information the Director may request or  
7 require.

8 Section 70. Funding of external review. The health carrier  
9 shall be solely responsible for paying the cost of external  
10 reviews conducted by independent review organizations.

11 Section 75. Disclosure requirements.

12 (a) Each health carrier shall include a description of the  
13 external review procedures in, or attached to, the policy,  
14 certificate, membership booklet, and outline of coverage or  
15 other evidence of coverage it provides to covered persons.

16 (b) The description required under subsection (a) of this  
17 Section shall include a statement that informs the covered  
18 person of the right of the covered person to file a request for  
19 an external review of an adverse determination or final adverse  
20 determination with the health carrier. The statement shall  
21 explain that external review is available when the adverse  
22 determination or final adverse determination involves an issue  
23 of medical necessity, appropriateness, health care setting,  
24 level of care, or effectiveness. The statement shall include

1 the toll-free telephone number and address of the Office of  
2 Consumer Health Insurance within the Division of Insurance.

3 Section 97. Severability. The provisions of this Act are  
4 severable under Section 1.31 of the Statute on Statutes.

5 Section 99. Effective date. This Act takes effect January  
6 1, 2010.